IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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August 31, 2006

William Miller, Administrator
Sunbridge Care & Rehabilitation for Twin Falls
640 Filer Avenue West
Twin Falls, ID 83301

Provider #: 135106

Dear Mr. Miller:

On **July 26, 2006**, a Complaint Investigation was conducted at Sunbridge Care & Rehabilitation for Twin Falls. Marcia Key, R.N. and Betty Vivian, R.N. conducted the complaint investigation. A total of 12 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001497

ALLEGATION #1:

The complainant stated residents in the Alzheimer's unit are allowed to wander into other residents' rooms, taking items and eating candy.

FINDINGS:

On July 25, 2006, resident care was observed in the Alzheimer's unit at 12:50, 1:15, 2:00 and 3:00 p.m. On July 26, 2006, resident care was observed at 8:35 and 10:30 a.m. During these observations residents were not wandering into other residents' rooms. Residents were participating in planned activities, or were in small groups sitting either near the nursing station or in the nearby common area.

The Unit manager was interviewed on July 25, 2006, at 2:15 p.m. A licensed nurse was interviewed on July 26, 2006, at 8:35 a.m., by a second surveyor. Both staff members stated that

in the recent past a resident had wandered in other residents' rooms at times but this resident was easily redirected by staff. The resident's care plan identified the resident was to be redirected by staff to prevent intrusion into other residents' rooms. There was no issue regarding this resident taking another resident's personal belongings or food. There had been no resident/family complaints regarding missing items or resident intrusions.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the facility found bruises on the chest and hands of an identified resident several times. They suspected a certified nursing assistant and terminated him. The bruising stopped. The complainant did not know if the person was reported to the Bureau of Facility Standards.

FINDINGS:

The surveyors reviewed the incident report and the investigation report completed by the facility. The Administrator was interviewed on July 26, 2006. He stated an allegation of employee to resident abuse was brought to his attention on May 25, 2006. Upon the completion of the investigation, the employee was terminated. The incident was reported to the Bureau of Facility Standards as required.

CONCLUSIONS:
Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated that many residents, who are incontinent and require two staff to change or assist them, do not get changed timely. One identified resident was noted to be urine soaked. On June 10, 2006, a second identified resident was noted to smell of urine and to have urine soaked clothing. He has had a very large sore on his scrotum for several years that is irritated by sitting in urine soaked clothing.

FINDINGS:

The two identified residents were observed on July 25 and 26, 2006. They were not observed to be wet from urine. Both residents were care planned to be toileted frequently during the day and night to prevent incontinence. The second identified resident's record was reviewed. The Physician Progress Notes identified the resident had a documented chronic condition causing the skin breakdown. The physician and wound specialist were monitoring the non-healing area. There was no documented evidence that the skin condition was deteriorating due to urine contact

with the area for extended periods of time.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser for

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

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August 17, 2006

William Miller, Administrator
Sunbridge Care & Rehabilitation for Twin Falls
640 Filer Avenue West
Twin Falls, ID 83301

Provider #: 135106

Dear Mr. Miller:

On **July 26, 2006**, a Complaint Investigation was conducted at Sunbridge Care & Rehabilitation For Twin Falls. Marcia Key, R.N. and Betty Vivian, R.N. conducted the complaint investigation. A total of nine survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001638

ALLEGATION #1:

The complainant stated the resident had been in a high/low bed during his hospitalization. The facility did not place the identified resident in a high/low bed upon admission when the staff was aware the resident was a very high fall risk. As a result, the resident fell out of bed and sustained a fractured hip requiring surgery.

The complainant also stated that the Director of the Alzheimer's Unit admitted to the complainant that she was aware the resident had been placed in a high/low bed while in the hospital. She also admitted that it was an error on the facility's part for not immediately placing the resident in a high/low bed.

FINDINGS:

The resident's record from the facility documented the staff performed a Falls Risk Assessment at the time of the resident's admission to the facility. He scored at "18," which represented he was at high risk for falls. The facility initiated a pressure alarm for the resident's bed and wheelchair. The morning after

his admission to the facility, the resident fell out of bed and sustained a left hip fracture. He was not in a high/low bed.

The facility's Falls Management System protocol identified; that residents who scored "10" or above required the development of a care plan with interventions implemented to prevent falls as possible.

The facility's Unit Manager for the Alzheimer's units was interviewed. She indicated the facility was aware of the resident's history of multiple falls and that the resident slept in a high/low bed while in the hospital. The previous falls were not related to the resident falling out of bed. She stated that the resident had no falls from bed while in the hospital. She also explained facility's practice to initiate a high/low bed only for residents who have had a history of this type of falls, as a bed placed in the low position could be considered a restraint for some residents. The facility did initiate a "fall" care plan and initiated safety measures upon his admission to the facility since he scored as high risk for falls.

The Director of the Alzheimer's Unit denied making the comment that the facility made an error by not placing the resident in a high/low bed.

The available history and physical reports from the treating physicians identified the resident had a history of multiple falls. There was no documentation that the resident had previous falls out of bed while living in the community or while in the hospital.

The appropriate safety measures were in place for this resident prior to his fall out of bed.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that the identified resident's electrolytes became abnormal while he was in the facility, and on July 16, 2006, he started thrashing about in bed. The resident was readmitted to the hospital with a very elevated sodium level and was near death due to dehydration. The complainant was told by a physician that the resident's condition had to be deteriorating for at least a week.

FINDINGS:

The identified resident's record documented he was at high risk for dehydration when he was admitted to the facility. His care plan identified approaches to ensure adequate fluid intake. He was closely monitored during meal times and his fluid intake during meals was monitored and documented by licensed staff. He was also on the hydration list for residents who were to receive oral fluids between meals. The resident was assisted to drink the fluids during these times by the activity staff, who also documented the amount of oral fluids he received.

The licensed nurse on duty in the Alzheimer's Unit during the investigation was interviewed. She

indicated that it is a practice in the facility to also offer fluids to residents when staff is in resident rooms. The fluids taken during these times are not tracked. She stated she did not work the weekend the resident was admitted to the hospital, however, the last day she observed the resident (she thought on Friday) he did not appear dehydrated.

The resident's meal monitor records, hydration/snack monitor records, and nurses' notes were reviewed. These records documented from July 8 through July 12, 2006, that the resident drank at least 1,200 milliliters or five 8 ounce glasses of fluids daily. There was no record of the fluids the resident received at other times during the day.

On the evening of July 12, 2006, the resident started experiencing a thick, productive cough. His oxygen saturations dropped to 64 % (normal range is greater then 90 %.) He became briefly unresponsive. A family member and the treating physician were notified. The resident was placed on oxygen, nebulizer breathing treatments, and was started on intramuscular antibiotic injections.

On the morning of July 13, 2006, his blood pressure was 92/56 and his temperature was 99.8 degrees. He drank at least 920 milliliters of fluids that day, refusing fluids during one meal.

On July 14, 2006, he drank at least 780 milliliters of fluids, at times only in sips. He ate the majority of his meals, however.

On July 15, 2006, the resident refused food and fluids during each meal. He drank 240 milliliters and 60 milliliters of fluids during the two hydration cart passes. The nurses' notes documented he was encouraged to attempt oral fluids during this time period. He had a very large diarrheal stool during the day and one episode of vomiting. During the evening he attended an activity and ate a snack. His vital signs were within normal limits. His complexion was noted be "pale." He continued to receive the antibiotic injections.

On July 16, 2006, at 4:30 a.m., the nurses' notes documented the resident was offered water but he refused. His oxygen saturation was 93 %. The documentation further identified, "cooperative and pleasant with cares. No diarrhea noted on this shift. (Decreased) alertness. Will cont. (continue) to monitor." In the early afternoon the nurses' notes documented, "Res (Resident) thrashing about in w/c (wheelchair) (no) swallow of meds (medications) or thickened fluids, layed (down) O2 (oxygen) placed at 2 L (liters) BNC (by nasal cannula) SA O2 (oxygen saturations) 92 %, afebrile resp (respirations) labored, lungs sl (slightly) diminished to (lower) lobes bilat (bilaterally) color pale..." The record also documented the resident's Power of Attorney was notified, and the on-call physician was notified at 1:40 p.m. The physician directed the resident to be transported to the emergency room.

The Director of the Alzheimer's Unit was interviewed. She stated the resident appeared his usual self when he attended the activity two days before his hospitalization. "He was in his wheelchair participating in kick ball."

The resident's hospital records were reviewed. The resident had been transported to the emergency room

on July 7, 2006, following a fall from his wheelchair. Blood study results identified an elevated sodium level of 154 (normal range 136 - 145.) The emergency room physician documented, "...In reviewing through the old records, it appears that the patient has been on piperacillin and tazobactam that has a large amount of sodium in it... I think this (the elevated sodium) is most likely medication induced..." The resident was not admitted to the hospital at that time.

The emergency room physician ordered a repeat sodium level on July 10, 2006. The sodium level on this date remained elevated at 153. The laboratory report identified that the resident's treating physician was faxed a copy of the report. There was no documented evidence the treating physician initiated medical treatment.

At the time of the resident's admission to the hospital on July 16, 2006, his sodium level was 165.

Based on the available medical information it could not be determined that the facility failed to prevent the dehydration. The resident's record during his stay in the facility documented attempted interventions to keep the resident hydrated. The physician was notified by fax regarding the elevated sodium, level on July 10, 2006. The treating physician was notified by telephone in a timely manner when the resident developed signs and symptoms of respiratory problems and became briefly unresponsive. The facility continued to closely monitor the resident and attempted to maintain his hydration. The resident experienced a large diarrheal stool and an episode of vomiting on July 15, 2006. He was able, however, to participate in the evening activity and snack. On July 16, 2006, the resident was noted to have labored respirations and he was transported to the hospital.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant was told by the treating physician that the resident had severe diarrhea and an impaction. The complainant thought abdominal x-rays were taken. The hospital staff was able to remove the impaction.

FINDINGS:

The resident's facility records documented he had a history of chronic constipation. There were documented bowel movements on June 27, 29, July 3, 6, 8, 9, 10, 12, 13, and 15, 2006. He received a dulcolax suppository on July 15, 2006, that had been ordered on an "as needed" basis for his constipation.

The resident was admitted to the hospital on July 16, 2006. The medical records identified the resident had a bowel movement the day prior to his admission. The next documented bowel movement was on July 17, 2006, and it was described as, ("...large, tarry, soft...") No documented evidence could be found that the resident had a fecal impaction removed.

The abdominal x-ray report, dated July 17, 2006, identified, "...The bowel gas pattern is non-obstructive in appearance. Stool burden does not appear grossly prominent; however, radiographs may not correlate with symptoms... Limited exam negative for bowel obstruction."

The physician's progress notes were reviewed. There was no documented evidence the resident had a stool impaction. The resident developed diarrhea while in the hospital. A stool sample was positive for C. difficile, and the resident was placed on Flagyl.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated he was informed by a facility ' s staff member that the resident had been vomiting and required a suppository for constipation a day or two prior to being admitted to the hospital. No family member was notified of the resident's change in condition.

FINDINGS:

The resident's nurses' notes from the facility documented a family member was notified on July 13, 2006, when the resident suddenly became unresponsive and showed signs/symptoms of an upper respiratory infection. The resident was given a suppository on July 15, 2006, for his history of chronic constipation. The suppository was a routine physician order for "as needed" basis. The facility ' s records documented the resident had an isolated emesis on July 15, 2006, but was able to participate in an activity later that day. The following day the resident's condition declined. The physician and a family member were appropriately notified at that time.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated he was informed by the treating physician that the resident had been receiving a large amount of Vicodin for hip pain while in the facility and might have been overmedicated.

FINDINGS:

The identified resident's record documented that at the time of his admission to the facility on June 27, 2006, the treating physician ordered Vicodin 5/500 milligrams three times daily and Ultram 50 milligrams three times daily for the resident's history of chronic pain. There was also an order for Percocet 5/325, one or two tabs every six hours on an as needed basis.

The record documented the resident received adequate pain control on these medications, and required the Percocet only one time, on July 9, 2006, for breakthrough pain. There was no documented evidence the resident was overmedicated on these ordered pain medications.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser for

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj